

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-016668**

**FILED VS MAY 13 1960**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2-4529**

1. PLACE OF DEATH a. COUNTY <b>O</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b _____	c. CITY OR TOWN <b>Saint Louis</b>
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1437 a Burd Avenue</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>LEONARD</b> Middle <b>NMN</b> Last <b>BURNS</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>26</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-14-1885</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City As Fault Dept. Warren, Arkansas</b>		11. BIRTHPLACE (City and state or country) <b>U. S. A.</b>		
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Hazel Burns</b>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>490-03-6735</b>	17. INFORMANT Address <b>Mrs. Hazel Burns 1437 a Burd Avenue</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>SUPERIOR MESENTERIC THROMBOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 HOURS</b>
DUE TO (b) <b>ARTERIOSCLEROSIS</b>		
DUE TO (c) <b>450.0</b>		<b>20 YEARS</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>INTRAPERITONEAL HEMORRHAGE</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY - Hour _____ a.m. _____ p.m. Month, Day, Year _____			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____
21. I attended the deceased from <b>APRIL 25, 1960</b> to <b>APRIL 26, 1960</b> and last saw her/him alive on <b>APRIL 26, 1960</b> Death occurred at <b>9:15 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <b>C. D. McMillan, M.D.</b>	22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>4/28/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>5-2-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cemetery St. Louis County, Mo.</b>	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR <b>Metropolitan Funeral System, Inc.</b> ADDRESS <b>5010 Enright</b>	25. DATE RECD. BY LOCAL REG. <b>APR 28 1960</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

MARSHALL UNIVERSITY

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John K. Cunningham

Licensed Embalmer No. 4476

P. O. Address 2405 Marcus A

**Note:** The above **MUST** BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.